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Justices of the Michigan Supreme Court
Supreme Court Clerk
P.O. Box 30052
Lansing, MI 30052

RE: Proposed Court Rule 2003-47

To the Honorable Justices of the Supreme Court of the State of Michigan:

On December 1, 2003, I wrote a detailed letter to you when Court Rule 2003-47 was first proposed. Since then, the American Thoracic Society (ATS) has published an official statement[(1)] on non-malignant asbestos-related diseases. The ATS is a pre-eminent association of specialists in respiratory medicine and science, with a long-standing interest in occupational lung disease and epidemiology. This Statement expresses the positions of the 11 experts, of whom I was recognized to be one, appointed by the Society to consider the diagnosis of these diseases. It was then reviewed and endorsed by the appropriate Assembly (Environmental and Occupational Lung Disease) and by the Board of the Society. <u>The ATS Statement is the appropriate source for any underline proposal concerning asbestos and pleural disease caused by asbestosis</u>.

I additionally had the honor to be one of "a group of ten of the nation's most prominent physicians in the area of pulmonary function" who was "interviewed at length at the Chicago

offices" of the American Bar Association by the Commission on Asbestos Litigation, to establish a Standard for Non-Malignant Asbestos-Related Disease Claims. I have been involved in the evaluation and care, clinical research and epidemiology of asbestos-related diseases for over 40 years, with joint professorships in (Pulmonary) Medicine and Occupational Medicine. I have evaluated tens of thousands of asbestos-exposed workers in a variety of occupations, and cared for hundreds of patients with these diseases in my academic and private practices. I spent considerable time in the State of Michigan in the 1970's as part of the Mount Sinai Medical School (New York) survey of the medical effects of polybrominated biphenyls (PBB's) which had contaminated the food chain in your State and in the 1980's surveying asbestos workers. I have published more than 30 articles in peer reviewed journals and chapters in 5 textbooks on medical effects of asbestos. I have served on expert committees to establish standards for pulmonary function tests, have published reference values for these tests and authored two textbooks on the use of pulmonary function testing in clinical and occupational lung disease. I have been an expert ("B") reader for more than 25 years, advised the National Institute of Occupational Safety and Health (NIOSH) on the radiographic diagnosis of asbestos-related disease and published papers which validate the International Labour Office (ILO) Classification of Pneumoconioses on which the B-reading is based.

At first, I considered the interaction between our noble professions to be a rewarding one. It has not proven to be. The ABA Standard for Non-Malignant Asbestos-Related Disease Claims does not reflect my statements or my many years of experience and research in these diseases, although my name and academic affiliation are listed therein. I received no advance draft of the Standard for my input. As an expert on asbestos-related diseases recognized both by the American Thoracic Society and the American Bar Association, I <u>have the responsibility to advise the court that a position paper by (underline) non-medical professionals is not an appropriate standard for addressing medical issues</u>.

The Supreme Court of the State f Michigan is again considering use of the ABA "Standard" to establish an Inactive Asbestos Docket. I feel it necessary to make it clear to this court that the "Standard" is not inclusive in insuring that valid claims of pulmonary impairment are admitted into the system, as it attests.* Rather, it is exclusionary and bars claims for many characteristic manifestations of such impairment.

1. Proposed Rule 2003-47 does not recognize that significant asbestosis can be present with barely detectable or no findings on an x-ray read by a B-reader (an x-ray profusion on the International Labour Office Classification less than 1/0 or even a normal x-ray). Evidence for this asbestosis is/can be manifest by pulmonary function tests, e.g., demonstrated decrease in forced vital capacity (FVC), total lung capacity (TLC), or diffusing capacity (DL) (with or without a decrease in forced vital capacity), or abnormality in ventilatory and gas exchange parameters on respiratory exercise testing. Diffusing capacity is available at any lung center, is standardized and [(2)] is known to be abnormal in interstitial lung disease (ILD) even when FVC and x-ray are normal. <u>The ABA "Standard" does not include Diffusing Capacity</u> or respiratory exercise testing. Perversely therefore, if DL is significantly decreased without a decrease in FVC, the X-RAY REQUIREMENT OF THE ABA STANDARD IS EVEN HIGHER (2/1).

   Evidence for asbestosis can be manifest by the pulmonary function test to which the ABA pays most attention, the FVC, when the x-ray is normal; this is not admissible under the ABA proposal.

2. <u>Asbestosis can be detected radiographically by CT scan when the x-ray is normal</u>. No provision for CT diagnosis is made in proposed Rule 2003-47. CT scan is universally

available in the U.S. and used by all pulmonologists in the assessment of ILD. It is inconsistent with standard practice anywhere in the United States not to utilize CT scan in the diagnosis of lung disease.

3. The section on impairment from asbestos-related pleural scarring is vastly insufficient. The ABA admits only bilateral diffuse pleural scarring of major degree. Diffuse pleural scarring can be associated with greatly diminished FVC regardless of the extent or thickness of the scarring on x-ray or its bilaterality [(3)]. It is therefore exclusionary to insist on "bilateral" diffuse pleural thickening of at least B/2 when pulmonary function is impaired by pleural thickening.

4. Circumscribed pleural scarring (also known as pleural plaques) comprises the vast majority of cases (80-85 percent. of patients with pleural scarring). The ABA bars all cases of circumscribed pleural scarring regardless of extent or thickness. Analysis of large numbers of patients reviewed in the American Thoracic Society Statement has shown that extensive circumscribed pleural scarring (plaques) can be associated with a significant decrement in FVC sufficient to bring about impairment in individual patients.

5. Impairing asbestosis and asbestos-related pleural scarring can co-exist with the most common pulmonary impairment, obstructive airways disease. The American Thoracic Society Statement makes it clear that asbestos inhalation can cause some degree of airways obstruction by itself [(4, 5)] Evidence also points to an interaction between asbestos and the most common cause of airways obstruction, cigarette smoking, in bringing about a combined (restrictive-obstructive) ventilatory impairment [(6)] in which the forced vital capacity (FVC) and the FEV_1/FVC ratio are both decreased. This combination of

findings, to which asbestos exposure has contributed, would bar a claim under Proposed Rule 2003-47.

6. Another common cause of airways obstruction is asthma. The finding of airways obstruction caused by asthma should not bar a demonstrated claim for non-malignant asbestos disease, any more than the presence of other common comorbidities like high blood pressure or diabetes.

7. Proposed Rule 2003-47 bars the use of an X-Ray Film which is less than optimum (quality 1). As a B-reader, I can sympathize with this requirement. In many cases, if the claimant is still alive and well enough to travel to an X-Ray facility, another attempt to obtain a quality 1 film is justifiable. An ill patient who cannot hold his breath in deep inspiration or remain in a fixed position may not be capable of providing an optimum film. A repeat examination is, of course, not an option for a deceased patient. Suboptimal films (qualities 2 and 3) are acceptable using the ILO Classification; unreadable films are designated as a separate category. Even in this situation, a film may be classified as unreadable for one purpose (pleural disease) but readable for another (asbestosis).

It is my hope that the considerations I have raised will cause re-evaluation of the Proposed Rule 2003-47.

Most sincerely,

Albert Miller, MD

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*"The Standard adopts less restrictive alternatives than some physicians recommended. The Commission recognizes that the effect of this may be to allow claims that do not really belong in the tort system, but PREFERS TO TAKE THAT APPROACH RATHER THAN TO UNFAIRLY EXCLUDE ANY SIGNIFICANT NUMBER OF DESERVING CLAIMS."

References:

1. American Thoracic Society Statement. Diagnosis and Management of Non-malignant diseases related to asbestos. Amer J Respir Crit Care Med 2004; 170:691-715.
2. American Thoracic Society Statement. Single breath carbon monoxide diffusing capacity (transfer factor). Recommendations for a Standard Technique. Am Rev Resp Dis 1987; 136:1299.
3. Lilis R, Miller A, Godbold J, et al. Pulmonary function and pleural fibrosis: quantitative relationships with an integrative index of pleural abnormalities. Am J Industr Med 1991; 20:145.
4. Rodriquez-Roisin R, Merchant JE, et al. Maximal expiratory flow-volume curves in workers exposed to asbestos. Respiration 1980; 39:58.
5. Begin R, Cantin A, et al. Airway function in life-time nonsmoking older asbestos workers. Am J Med 1983; 75:631.
6. Miller A, Lilis R, et al. Spirometric impairments in long-term insulators. Chest 1994; 105:175.